Michigan Brain Drain
How Many Physicians Are We Losing From Underfunded GME?

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The Difference Between a Living Will and a Medical Treatment Power of Attorney

By Daniel J. Schulte, JD

The term “Living Will” is used to describe a document containing an expression of a patient’s desire to receive medical care (and may include the person’s desires concerning the providing or withholding of life-sustaining care) during a period of incapacity rendering them incapable of giving informed consent for or refusing medical care. This is a form of a Will (a document pursuant to which an individual directs the administration of their affairs, property, etc. when they are no longer able to do so on their own) used while the person is still alive; thus the description, “Living Will.” Living Wills take many forms. There is no Michigan statute specifically governing the form or content of a Living Will. Living Wills are not legally binding; physicians and other health care providers are not required to follow the desires and/or directives of a patient contained in a Living Will.

Similarly, a Medical Treatment Power of Attorney may include statements of a patient’s desires regarding the receipt or refusal of medical care (including the designated patient advocate has the legal authority to make medical treatment decisions on behalf of the patient while the patient is incapacitated.

MCL 700.5509(c) specifically provides that a patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision and that the patient acknowledges that such a decision could or would allow the patient’s death. The best way to so clearly and convincingly make this authorization and acknowledge that the exercise of this authority could result in death is to say so in the Medical Treatment Power of Attorney. Therefore, assuming all of the statutory requirements are met for a patient’s Medical Treatment Power of Attorney to be valid and the patient has included in his/her Medical Treatment Power of Attorney a specific directive that life sustaining medical treatment be withdrawn or withheld in certain situations and acknowledges that the withdrawal or withholding of such care will result in death the patient advocate has the authority to make such a decision on behalf of the patient. This decision of the patient advocate is legally binding on physicians and other health care providers to the same extent as if it had been made by the patient himself/herself.

A Living Will only documents the desires of the patient. It does not provide authority to make medical treatment decisions, which must be followed by physicians. A Medical Treatment Power of Attorney complying with the statutory requirements does create this authority in the patient advocate.

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Daniel J. Schulte, JD, MSMS Legal Counsel, is a member of Kerr, Russell and Weber, PLC.

EDITORS NOTE:
If you have legal questions you would like answered by MSMS legal counsel in this column, send them to: Jessy Sielski, Michigan Medicine, MSMS, 120 West Saginaw Street, East Lansing, MI 48823, or at jsielski@msms.org.
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Medical clearance does not clear the patient or physician of risks
Contributed by The Doctors Company

“Medical clearance” is when a surgeon requests clearance from an assessing physician before performing surgery on a patient. Cardiac risk is the number one reason to request medical clearance, but other risks that call for medical clearance include congestive heart failure, pulmonary embolism, anticoagulation, obesity, and high blood pressure.

Anticoagulants, for example, are often an issue in surgical claims. If the patient is taking anticoagulants, the surgeon should agree on the best approach for that specific patient. They may discuss changes in medical management that should be made to decrease risk. If they believe the patient is at risk from a respiratory perspective, the focus may be on early mobilization, incentive spirometry, and respiratory treatment.

To avoid malpractice risks, consider the following tips when dealing with medical clearance:

• DETERMINE WHICH PATIENTS NEED MEDICAL CLEARANCE. The surgeon should assess the type of surgery and its associated risks and the health of the patient. Healthy patients with no underlying conditions who are undergoing fairly low-risk procedures don’t routinely need medical clearance.

• PROVIDE APPROPRIATE INFORMATION. Problems can arise when the surgeon does not provide enough information to the assess physician about the surgery being proposed. The surgeon should provide information to the assessing physician about the type of surgery, how long it will take, what kind of anesthesia is anticipated, how long the patient will be immobile, what is involved in rehabilitation, and what the recovery period looks like. The assessing physician should take that information into consideration, along with exam results and knowledge of the patient, to determine if the patient is at increased risk.

• DEVELOP A PLAN TO MITIGATE RISKS. The surgeon and the assessing physician should work together to determine the steps to take to mitigate risk preoperatively, intraoperatively, and postoperatively. For example, they should agree about which medications to stop preoperatively and which to continue.

There is no standard medical clearance process. Physicians should be aware of when a medical clearance would be indicated and have a good process to ensure it’s done.

Medical clearance is a misnomer because it implies that the patient is cleared and there are no risks. No patient is free of risk when undergoing a procedure. The goals of the assessment are to determine the level of risk and to identify opportunities to mitigate risk – with the surgeon and the assessing physician working in concert. The decision about whether to proceed with the operation belongs to the surgeon and the patient.

The physicians of the Michigan State Medical Society remember with respect their colleagues who have died.

George H. Koepke, MD
Findlay, OH
Died November 26, 2013, at the age of 97.

Everett H. Johnston, MD
Spring Lake,
Died December 12, 2013, at the age of 90.

John W. Cavendish, MD
Saginaw,
Died December 14, 2013, at the age of 72.

Calvin J. Dykman, MD
Grand Rapids,
Died December 15, 2013, at the age of 75.

Ernest M. Berkas, MD
Golden Valley, MN, formerly of Dearborn and Cheboygan,
Died December 25, 2013 at the age of 87.

Brian L. Hotchkiss, MD
Grand Rapids,
Died December 27, 2013, at the age of 75.

IN MEMORY
If you would like to recognize a colleague by making a gift or bequest in their memory to the MSMS Foundation, please contact Rebecca Blake, Director, MSMS Foundation, 120 W. Saginaw St., East Lansing, MI 48823, call 517-336-5729 or e-mail rblake@msms.org.

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If given the choice, second year medical student Nicolas K. Fletcher would complete his residency training in Michigan and remain in his beloved Midwestern state to start his career as a practicing physician.

However, the Michigan State University College of Human Medicine student knows his ideal residency location may be out of reach because of a lack of graduate medical education (GME) funding. Fletcher will soon be vying with hundreds of other doctors for a limited pool of state residency spots - a reality that, unfortunately, may force him elsewhere.

“One of the discussions my wife and I have had is, although we’re both out-of-state students, we’ve come to really love Michigan and appreciate what western Michigan has to offer,” said Fletcher, Chair of the MSMS Medical Student Section and an expectant father. “I would like the opportunity to stay in Michigan. GME [funding] should not be one of those issues...
influencing my decision of where I can go. You should not have to deal with the fact they just don't have enough spots.”

Frustration among Michigan physicians, medical students and hospitals is growing as the federal freeze on residency slots continues to drive talented young doctors out of the state. The government in 1997 placed a cap on the number of Medicare-supported residency spots in the US, a limit tied to the number of residents that teaching hospitals reported in 1996. The cap means that despite a growing number of medical graduates across the country, the same limited number of training slots remain. The freeze is even more challenging for states such as Michigan that recently opened new medical schools.

“In the last few years, we have opened three new medical schools: Oakland [University William Beaumont], Western Michigan University and Central Michigan University,” said John E. vanSchagen, MD, program director for the GRMED/MSU family medicine residency and associate chair for the Grand Rapids Michigan State University College of Human Medicine department of family medicine. “The remaining traditional schools have all expanded their class sizes dramatically. The bottleneck comes back to GME. We're coming up on 20 years without an increase in the number of slots that have been available in our state.”

Physician leaders continue to examine potential solutions to the GME dilemma, including legislative remedies, new residency structures and alternative GME funding sources – but questions remain as to whether these solutions are feasible and if such repairs will come in time.

Residency Funding by the Numbers
Nationally, Medicare pays about $10 billion toward GME, both through direct and indirect payments. Direct payments refer to expenses for resident salaries and supervising physicians’ time. Indirect payments subsidize other hospital costs associated with running training programs. Indirect payments are based, in part, on the number of residents a hospital trains and the number of Medicare patients it treats.

Michigan receives close to $168 million annually from Medicare. The state itself pays about $54.7 million.

Michigan directs a portion of state funding to GME as well. State Medicaid programs are not obligated to pay for GME, but most states historically have made such payments under their fee-for-service programs. A 2012 AAMC report ranked Michigan among the 15 states that contribute the highest GME payments. Michigan is one of only nine states that include Medicaid GME payments in its capitated payment rates to managed care organizations. In 2012, Michigan paid $163 million toward GME, according to AAMC data.

Despite its contribution, Michigan is providing significantly less for GME than in previous years. In 2011, state lawmakers cut six percent from its GME funds. Further state cuts could be on the horizon. Meanwhile, the Obama administration has proposed cutting $11 billion from GME over the next decade in its fiscal 2014 budget. The cuts would represent about 10 percent of Medicare’s contribution to GME.

“The national outlook is dismal,” said Richard Cooper, MD, director of the Center for the Future of the Healthcare Workforce at New York Institute of Technology and a senior fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania. “If a group of economists and policy-makers who, in our view, are totally out of touch with reality and therefore continue to argue against expanding supply. It's really appealing to Congress because to do nothing doesn't cost anything.”

Nationally, more than 500 medical school graduates are already unable to match with a residency annually, according to American Medical Association data. That number is expected to grow as the pool of medical school graduates rises.

The value and importance of GME is becoming lost as the federal government focuses on thinning its budget, said Atul Grover, MD, PhD, AAMC chief public policy officer.

“The major problem right now is a climate of deficit reduction in DC where Congress is looking to cut spending and not looking at the long-term need to invest in the workforce,” he said.

New doctors provide most uncompensated care
Medical residents are well worth their training expenses, physician experts say. They provide substantial medical care for much less than their fully-trained physician counterparts.

“Residents work up to 80 hours per week and are typically paid less than $50,000 per year, representing an incredible value
in health care delivery,” said Laura Appel, vice president of federal policy and advocacy for the Michigan Health & Hospital Association. In addition, “residencies typically are located at hospitals serving disadvantaged populations. These doctors are essential to caring for Medicaid patients and those without health insurance.”

In 2013, Michigan’s Medicaid caseload was close to a record high of nearly two million people. An additional 1.2 million patients lacked health insurance, Appel said. In fiscal year 2011, [the most recent annual data available], Michigan hospitals provided nearly $1.9 billion in uncompensated care, including more than $882 million in financial assistance at cost and uncollectable funds.

Nationally, teaching hospitals provide close to 40 percent of all charity care in the US, according to AMA data.

Because of the necessity of residents, hospitals often use a portion of their own budget to pay for additional slots or costs associated with residencies, said Michael J. Ehlert, MD, a Detroit urologist and member of the Michigan State Medical Society Board of Directors. But budget constraints are forcing many hospitals to pull back on extra residency funding, he said.

“As hospitals make less and less money and there is [federal] pressure on hospitals to basically not spend as much, the money is not going to be there anymore [for residents],” he said. “There’s not enough fat on the meat. It’s harder for them to fund these spots.”
When it comes to residency slots, Michigan has long had one of the highest numbers of spots in the country.

“We’re pretty high on the list,” said Peter Coggan, MD, MSEd, vice president and chief academic officer for CHE Trinity Health in Livonia. “[Michigan] has had more teaching hospitals, the population density is greater and there’s more of a tradition of teaching. [The state] has had residency programs in their hospitals going back to the 1940s and 50s.”

In the 2013 match, Michigan had a total of 1,261 allopathic residency slots and 478 osteopathic residency spots, according to data from the National Resident Matching Program (NRMP) and the American Osteopathic Association.

In the past, the ratio of Michigan medical students to residencies allowed for more graduates to find residencies in-state. However, like other states with new medical schools, that proportion is quickly shifting.

“It’s not [a bad] thing that we’re trying to make opportunities available for talented young women and men to get trained,” as doctors, said Theodore B. Jones, MD, FACOG, residency program director, obstetrics and gynecology at Oakwood Hospital and Medical Center in Dearborn. He serves on MSMS Board of Directors. “But when that training is over, and they go on to post-graduate training, the [question is], are we going to have enough slots?”

Research shows that medical students commonly practice in the area where they complete their residency, adds Andrew Moriarity, MD, senior resident in radiology at Henry Ford Health System. Thus, a lack of residency spots means graduates who move for their graduate training likely won’t be returning, he said.

“A lot of the medical school and residency education can be viewed as an investment in the state,” said Doctor Moriarity, a graduate of Wayne State University School of Medicine. “It would be good for the [legislators] to realize that by [increasing] GME funding, they’re actually encouraging those same doctors to stay, rather than moving elsewhere.”

Along with Michigan medical school graduates, the scarcity of residency slots and growing graduate pool also presents challenges for international medical school graduates.

In 2013, IMGs accounted for more than one third of the residency applicant pool in the US, including 7,568 non-US citizen IMGs and 5,095 US citizen IMGs, according to the NRMP. In Michigan, IMGs make up about 10 percent of the physician workforce, according to a 2013 AMA-IMG Section Governing Council report. The state also had the second highest number of physicians holding J-1 visas in the 2010-2011 academic year at 552, according to the report. Only New York had more J-1 physicians at 1,227.

But international medical graduate advocates are concerned that when push comes to shove, IMGs are most likely to miss out on residency spots.

“The priority of the [GME] funding is going to be for US graduates,” said Rima Jibaly, MD, a Flint pediatric gastroenterologist who serves on the MSMS International Medical Graduate Section Governing Council. “We feel that it’s going to affect international graduates more than anybody else.”
Whether residency programs choose US-born applicants over IMGs will depend on the program and each specific school’s goals, Doctor Jones said. But, it’s possible gifted international doctors will be overlooked because of limited residency spots, he said.

“I have found through the years that there are some pretty extraordinary international medical graduates that are in the applicant pool,” he said. “I have had no regrets considering them for training and watching them develop into really outstanding doctors. It really just depends on how you want to look at the pool of talented individuals.”

Examining Potential Residency Remedies
Various solutions have been proposed to address the GME funding dilemma, namely pushing Congress to lift the freeze on federally-funded residency slots.

Paying for More Slots
Finding alternative forms of funding could also help pay for more residency slots. Doctor vanSchagen notes that some insurers and third-party payers already subsidize some portion of medical education. Expanding these contributions could potentially help solve the shortfall.

Other theorists have suggested shortening the length of residency, thereby freeing up some open spots and allowing for more residents to train at a time, Doctor Cooper said. But he argues that medical residents need all the training they currently receive.

“That’s not a good idea,” he said of shortening residency. “Medicine is getting more complicated rather than less complicated.”

Redistributing residency funding to target the specialties most in need of physicians is another idea. The strategy would be to ensure the proportion of specialists in training comes closer to meeting physician workforce needs, Doctor Coggan said. “If we’re going to need more primary care physicians, perhaps funding for primary care residencies would be favored,” he said. “The same might be true for general surgery. We’re approaching a bit of a crisis of the numbers of residencies that can be trained ties the hands of our medical schools and our teaching hospitals,” Crowley said in a statement. “Increasing the number of residency slots, along with maintaining sufficient resources for our teaching hospitals, will enable us to continue developing the highly-trained physician workforce we need.”

In January, a bill that would modify a program that re-pays student loans for certain physicians in underserved areas moved out of the Senate Appropriations Committee with amendments. Senate Bill 648, sponsored by Sen. John Moolenaar (R-Midland) and supported by MSMS, would remove the four-year limit on loan repayments, increase the maximum annual loan repayment, and establish a lifetime cap on loan repayments. The idea, according to the bill sponsor, is to incentivize more medical students to choose to practice primary care in rural and underserved parts of the state. The bill also would permit the Michigan Department of Community Health to give preference to physicians studying general practice, family medicine, obstetrics and gynecology, pediatrics, or internal medicine. Watch Medigram for further developments.

Learn more about state and federal loan repayment programs at www.msms.org/gme.

The AAMC advocates that the government increase GME positions by at least 15 percent, a figure that would allow teaching hospitals to train another 4,000 physicians a year.

“We have to work with the federal government to increase the number of funded positions so that we can actually have more training positions in the state,” Doctor Coggan said. “There have been several bills in the last few years advocating for an increase in federal funding for positions, but they haven’t gone anywhere because those bills have been published at a time” when there were serious concerns about the total federal budget.

Most recently, US Reps. Joe Crowley (D-New York) and Michael Grimm (R-New York), reintroduced the Resident Physician Shortage Reduction Act of 2013. The act would create 15,000 new GME slots over five years. As of March 2013, the bill was assigned to a congressional committee that will consider it before potentially sending it on to the House or Senate.

“Our country needs us to do all we can to alleviate the coming doctor shortage, yet an outdated limit on the number of doctors that can be trained ties the hands of our medical schools and our teaching hospitals,” Crowley said in a statement. “Increasing the number of residency slots, along with maintaining sufficient resources for our teaching hospitals, will enable us to continue developing the highly-trained physician workforce we need.”

The author is an Indiana-based medical writer.
In December 2013, Gov. Rick Snyder signed into law a pair of bills (HB 4352 and 4353) sponsored by Rep. Lisa Lyons (R-Alto) and supported by MSMS that will protect Michigan children suffering from dangerous and life-threatening food allergies at school. The new law requires public schools to have two epinephrine devices on site and to ensure at least two staff members are trained to use them. It will take effect in the next academic year. MSMS worked with the Michigan Allergy & Asthma Society to support the bills.

“There's nothing more important than keeping our kids safe and healthy, and lawmakers took a big step in that direction by voting to protect them from life-threatening food allergies at school,” said MSMS President Kenneth Elmassian, DO, an Ingham County anesthesiologist, after the bills passed.

Matthew Greenhawt, MD, a Washtenaw County allergist who testified before the Senate Education Committee in support of the bills, added, “Death from an allergic reaction can be 100 percent preventable with epinephrine. I applaud the state Legislature for recognizing this, and swiftly ratifying a bill that can help prevent any further tragic, and unnecessary outcomes. Their decision to put epinephrine in every school makes Michigan a national leader that other states should follow when it comes to student safety.”

Children are among the most vulnerable to allergic reactions and anaphylaxis, a severe reaction that can be fatal within minutes through swelling that shuts off airways or through a drop in blood pressure. Kids who are exposed to a potential food allergy need immediate help in the critical minutes following an exposure.

The author is senior manager of communications at MSMS.
American poet Robert Frost poignantly wrote in different poems about the middle and end of life – taking “the road less traveled by” and having “miles to go before I sleep.” Both of these sentiments reflect on the importance of making choices that set the course for the remainder of one’s life. These spark important philosophical considerations for physicians in the care they give their patients.

What happens when you diagnose (or discover) a patient’s condition as terminal and life-shortening? And how can and should physicians help patients cope with this process?

It may not be a topic that draws most people into medicine as a career – after all, physicians have historically been trained to focus on saving, improving, and extending lives.

But many physicians who specialize in palliative and hospice care are hoping to see a cultural shift in the way their colleagues approach with their patients the process of dying.

## Going in the Right Direction

Carol L. Scot, MD, an internist and palliative care specialist with the Sparrow Hospital Palliative Care Team in Lansing, is one of them.

“Hospice care is still looked at as giving up,” she says. “It’s almost something that a person has to see first-hand to trigger a true understanding of the benefits.”

Doctor Scot, who was a divorced mother of four before she decided to pursue medicine as a career, knew in her third year of medical school at the University of Kentucky that she wanted to work in hospice care. She heard a compelling lecture given by Dame Cicely Saunders, the British physician who is credited with opening the first modern hospice in 1967 near London and with introducing the concept of hospice care to the US in 1969.

“I was impressed by the pictures she shared of patients in agony as they arrived at her facility, and then pictures of the same patients after receiving hospice care. They were comfortable, sitting up, enjoying the outdoors,” recalls Doctor Scot. “I wanted to be a part of that process. Her lecture convinced me to work in hospice.”

Although Doctor Scot admits that practicing hospice and palliative care was more difficult than she’d expected – “deciding whether to administer comfort or [medical] care” – she truly believes in the benefits.

“Good palliative care should always be practiced. It’s putting a cold washcloth on a patient’s head or propping them up with an extra pillow,” she explains. “It’s the human response to pain and suffering.”

But palliative and hospice care is still a relatively new discipline in the US.

“In the late 1970s and early 1980s when I was a doctor in training, hospice and palliative care didn’t exist. More often than not, a dying patient was viewed as a practitioner’s and the health care ‘system’s’ failure – a failure of technology and know-how to cure disease or at least to extend life,” wrote Risa Lavizzo-Mourey, MD, MBA, President & CEO, Robert Wood Johnson Foundation, in a 2011 report called Improving Care at the End of Life. “Too often, I observed two equally inadequate responses to this perceived failure – apply more...
“Good palliative care should always be practiced. It’s putting a cold washcloth on a patient’s head or propping them up with an extra pillow. It’s the human response to pain and suffering.”

— Doctor Scot

technology more intensively or withdraw completely – physically and emotionally.”

It wasn’t until 2006 when the American Board of Medical Specialties recognized hospice and palliative medicine as a medical subspecialty. And in 2008, the US Centers for Medicare & Medicaid Services followed suit.

Sparrow Hospital, where Doctor Scot works, started its Palliative Care Team in 2002.

Medical schools now offer palliative and hospice care courses as electives, and the American Medical Students Association offers an end-of-life care fellowship.

According to the annual report of the Hospice & Palliative Care Association of Michigan issued last spring, there were 116 licensed hospice providers in Michigan in 2012, with 40 licenses pending in the Michigan Department of Licensing & Regulatory Affairs, as of February 2013.

“We’re going in the right direction now,” notes Doctor Scot.

“Physicians are a lot more knowledgeable about pain management drugs, for example, and anywhere you live, you can get hospice care, so those are big improvements.”

Educatings Your Patients

As the nation moves toward an era where one-quarter of the population will be classified as “elderly,” hospices will be looked upon for needed assistance. MSMS offers several resources to assist physicians. MSMS has received a grant from Blue Cross Blue Shield of Michigan to educate physicians and patients about end-of-life care options by re-issuing its End-of-Life Care Guide, a 48-page comprehensive booklet addressing all aspects of end-of-life care: communication, advance directives, pain management, hospice and palliative care, and spirituality. Also, MSMS will be presenting a series of webinars on end-of-life care issues.

MSMS continues to offer Durable Power of Attorney forms, and has sold/distributed more than five million of these forms since 1990. Customers include hospitals, physician offices, lawyers, hospices, and individuals. Experts urge everyone over the age of 18 years to get one and review it every year to update information. They don't even need an attorney.

See the “Ask Our Lawyer” column in this issue for more information about medical treatment power of attorney.

“Hospice care not only encompasses effective and wonderful care for the patient, but it also serves as ‘prophylactic care’ for the family,” said Doctor Scot about emotional difficulties that families of dying patients often face.

The author is senior manager of communications at MSMS.
From Babies to Michigan’s Newest Medical School,

It’s All in the Delivery for Doctor Burns

By Stacy Sellek

She might not be answering calls in the middle of the night anymore after a patient goes into labor, but Elizabeth Burns, MD, MA, is still delivering in another way as she helps to launch the state’s newest medical school: Western Michigan University School of Medicine (WMed).

“I’ve always been in education,” explains the veteran family physician. “I started with a fellowship at University of Iowa and stayed on to teach. A good family doc is always teaching – their patients, first and foremost.”

As WMed prepares to welcome its first class in August, Doctor Burns will prepare to don her “professor” hat once again.

But more recently, Doctor Burns was instrumental in bringing her colleagues at WMed into MSMS through a group membership.

Mutual Interests

A Michigan native who was born in Detroit, Doctor Burns only recently returned to her home state after practicing and teaching in several other states (e.g., Iowa and North Dakota, among others) over the years. She earned her medical degree from the University of Michigan and completed her residency at Harrisburg Hospital in Harrisburg, Pennsylvania.

Once she joined the WMU faculty in 2012, Doctor Burns became dedicated to building a top-notch medical school and connecting its faculty and students with the local community through organized medicine.

“We wanted our faculty to be part of KAM [Kalamazoo Academy of Medicine] and MSMS, and we want to have students, residents, and young physicians involved, too,” she said. “It’s important for a medical school to work with the physicians in the community and the county and wider region, as a whole.

“MSMS is a great place to get to know those folks, and KAM, too,” she added. “The county medical society is a place for local private practice physicians to get to know academic physicians so we can come together because we have mutual interests.”

Addressing those mutual interests collectively is what’s important about organized medicine, according to Doctor Burns, who has been a member of MSMS and KAM since 2008 when she returned to Michigan.

“I’ve been a member of the state and county medical society of every place I have practiced,” she said. “While the specific benefits might vary by location, I do think that state societies give physicians the opportunity to come together as a profession, talk about how challenges are affecting their practices, and talk about goals of where you would like medicine to be. That’s the advantage of belonging.”

Regarding MSMS membership, in particular, Doctor Burns believes that knowing what it takes to build a medical school, involvement in graduate medical education issues, and advocacy issues such as Medicare Advantage make MSMS a valuable resource to physicians at WMU.

Leaning in and Stepping Up

“I was always thinking about medicine or nursing as a career,” Doctor Burns explains. “I had an interest in science and in helping people. As I thought about career options, it seemed like a real challenge at the time.”

Although she doesn’t miss being on call, Doctor Burns, who stopped practicing in 2008 when she left North Dakota for Michigan, doesn’t hesitate in answering what she missed the most about practicing: “The interaction with patients. Developing relationships with patients and their families.”

But, with her parents getting older and encountering health issues here in Michigan, she began looking “very selectively” for job opportunities back in her home state. Then in 2008, she took the position of President & CEO at Michigan State University Kalamazoo Center for Medical Studies before accepting her current position in 2012 as Associate Dean for Faculty & Clinical Affairs and DIO at WMed.

What advice does Doctor Burns have for other physicians who want to make a difference or take on leadership roles?

“Sheryl Sandberg talked about leaning in. Lean in, step up, and don’t just complain, but put your thoughts into action,” she advises. “Talk to our congressional delegation and local lawmakers. Work through organized medicine. You’re not always going to get what you want, but you will learn a lot about yourself.”

Doctor Burns addresses Western’s graduating residents in June 2013.
One issue Doctor Burns has much experience advocating for is GME, which she shares some thoughts on: “We need funding through the federal government. State lawmakers need to be the voice at the federal level to say what they need in respect to physician workforce, and maybe thinking of alternate methodologies of support and funding. Physicians need to be a part of this advocacy by educating lawmakers.”

As far as her own career goes, Doctor Burns considers her greatest professional achievement to be the care she’s provided her patients. “I still hear from patients, and I’m privileged to have maintained contact with many of them over the years. To see them flourish and do well has been a wonderful experience. You never really stop being a physician,” she says.

As for finding balance in her busy life, Doctor Burns says that she is “still searching for that…sometimes we have to learn the hard way,” she laughs.

“I do think that state societies give physicians the opportunity to come together as a profession, talk about how challenges are affecting their practices, and talk about goals of where you would like medicine to be. That’s the advantage of belonging.”

— Doctor Burns

One thing that helps is to talk to her husband, who holds a PhD in botany and taught pre-med students back when they were living in Illinois and North Dakota. And she believes it’s important to talk to her colleagues.

“We have an obligation toward one another in the profession to talk with people who are feeling ‘burned out’ because it’s easy to get down in the dumps in this profession,” she points out. “We need be aware and watch others to see how they are doing; ask if they are ok, particularly residents during this time of year.”

Moving forward, Doctor Burns is firmly focused on the task of getting the medical school launched, but also her goals of strengthening primary care residency programs; and she would like to see a revitalization of primary care in academic health centers.

“I think we will be able to do that with strong residency programs that are training and educating residents to be excellent clinicians,” she says.

The author is senior manager of communications at MSMS.
Electronic Health Record Malpractice Risks

By David B. Troxel, MD

The Doctors Company supports the integration of the electronic health record (EHR) into medical practices and believes it has great potential to advance both the practice of good medicine and patient safety. However, there are always unanticipated consequences when new technologies are adopted – and the EHR is no exception. Real and potential liability risks are beginning to be recognized, and it is important for physicians to become familiar with them.

1. Doctors are responsible for information to which they have reasonable access – and there is increased access to e-health data from outside the practice that is accessed from the practice EHR or website or through Health Information Exchanges, e.g., hospital charts, consultants' reports, lab results and radiology reports, and community medication histories. EHR metadata documents what was reviewed. If patient injury results from a failure to access or make use of available patient information, the physician may be held liable.

2. E-prescribing is being rapidly adopted, driven by federal financial incentives, and is currently used by more than 50 percent of office practices. Potential capabilities and benefits include:
   - Most electronic prescriptions are transmitted via a Surescripts network (which has data on more than 70 percent of patients) to all chain pharmacies, 60 percent of independent pharmacies, and most insurance formularies.
   - EHRs have an e-prescribing module, which is a required capability under the federal financial incentives for “Meaningful Use” of EHRs. E-prescribing provides electronic routing to pharmacies, quick access to drug formulary and eligibility information, and the patient's prescription history.
   - Standalone e-prescribing software is also available at no cost from Allscripts and the National ePrescribing Patient Safety Initiative (NEPSI).
   - Most e-prescribing programs check for drug interactions, dosage errors, medication allergies, and patient-specific medication factors.
   - Office prescription renewal requests can be synchronized with most e-prescribing systems.
   - E-prescribing encourages patients to fill prescriptions (currently 30 percent do not), because the prescription is sent to the pharmacy electronically and is ready to be picked up when they arrive.
   - Costs are lowered by flagging generic and “on-formulary” drugs.

However, practices are exposed to community medication histories through e-prescribing. For example, Dr. A renews a medication, and his e-prescribing program sends an alert advising him that the medication could interact with another drug the patient is taking. He has not prescribed that drug, so his office staff will have to contact the patient to identify who has prescribed it, and then Dr. A will have to contact Dr. X to “negotiate” which drug will be discontinued or changed. If failure to take action results in patient injury from a drug interaction, Dr. A may be liable.

3. Drug-drug interaction lists generate frequent, annoying, and disruptive alerts, and doctors may develop “alert fatigue” and ignore, override, or disable them. If it can be shown that following an alert would have prevented an adverse patient event (this will be documented in the metadata), the physician may be found liable for failing to follow it.

4. Doctors may copy information from a prior note or the history and physical (H&P) and paste it into a new note or H&P (known as “cloning”), making changes where appropriate. This works well for the past history but is risky for the physical examination, which may change. This may result in irrelevant over-documentation, and the patient may appear to have more or less complex problems since the prior encounter. By substituting a word processor for the physician's thoughtful review and analysis, the narrative documentation of daily events and the patient's progress may be lost, thereby compromising the record of the patient’s course. The quality of notes and documentation may be further compromised by the use of templates.

5. The computer may become a barrier between the doctor and the patient. When the doctor fills in a computer template, it may divert attention from the patient, limit interactive conversation, and restrict creative thinking. This may depersonalize and weaken the doctor-patient relationship. The computer’s location in the office is an important ergonomic consideration; i.e., the location of electrical outlets shouldn’t force you to sit with your back to the patient.

6. Many EHRs autopopulate fields in the H&P (from data derived from data fields in a prior H&P) and in procedure notes (from personalized or packaged templates). While
over-documentation may facilitate billing, entering erroneous or outdated information may increase liability. For example, an internist was deposed and his EHR was the medical record. Some of the autopopulated fields contained obviously wrong information. At deposition, the plaintiff’s attorney asked these questions:

a. “So is the information in this record accurate or not?”
b. “Do you bother looking at your records?”
c. “If these ‘autopopulated’ fields are incorrect, can we trust anything in this record?”
d. “Do you deliver the same level of care as you do in record keeping?”

EHRs are certified for compliance with Meaningful Use requirements, e.g., computerized provider order entry (CPOE), e-prescribing, Clinical Decision Support (CDS), and patient connectivity through Patient Portals. Patients must be provided with clinically relevant, disease-specific educational and drug safety materials through these portals. Providers are responsible for the content, which creates risk. Some EHRs have patient questionnaires that use an algorithm to interview the patient through these portals. The questionnaires may address – and memorialize in the record – issues that physicians are not prepared to pursue (depression, substance abuse, sexually transmitted disease, etc.). Lack of or incomplete follow-up can create potential liability – and provide a clear record for the plaintiff’s attorney to follow.

Vendor contracts may attempt to shift liability resulting from faulty software design or CDS data onto the physician. Malpractice policies may exclude coverage for product liability and indemnification of third parties. Read all contracts carefully.

Electronic discovery: Lawyers may request printed copies of the EHR and also copies in native format, which shows how the data was used. (Were CDS alerts and prompts followed or overridden?) They will also request the metadata, which includes logon and logoff times, what was reviewed and for how long, what changes or additions were made, and when the changes were made. Smartphone and e-mail records are also discoverable. All physician interactions with the EHR are time-tracked and discoverable.

Computer-assisted documentation uses point-and-click lists, drop-down menus, auto-fill, templates, and canned text to bypass natural language and produce structured progress notes. These contain redundant, formulaic information, making it easy to overlook significant clinical information that is lost in a sea of normal or irrelevant findings. Communication with on-call and consulting physicians may be compromised, and abnormal lab and imaging test results may be missed.

CDS provides alerts, warnings, and reminders for medication and chronic disease management and preventive care, but physicians may have to justify departures from these guidelines (documented in the EHR’s native format) if an adverse event occurs. Always document why a prompt was overridden.

The author is Medical Director, Board of Governors, The Doctors Company.

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The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each health care provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.
Diversification Matters
Ignore the Temptation to Chase Last Year’s Winners
By Nathan Mersereau, CFP, AAMS

Have you ever looked at a financial magazine and kicked yourself for not holding the investment touted on the cover? The media does a great job of promoting the hottest performing investment while prodding you to make sure you hold it in your portfolio. It may seem natural to want to buy more of anything that is doing well, but investors often buy high-performing investments too late in a market cycle while holding the belief that if a little is good, more is better. The result is a portfolio filled with excessive risk and volatility.

The table below ranks nine major asset classes from highest to lowest performance on an annual basis. The blue category, Asset Allocation, is a blend of all nine asset classes into a moderate risk portfolio. So, what was the best performing asset class from

<table>
<thead>
<tr>
<th>Asset Class Returns</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
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<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>10 Year Total</th>
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<td>34.5%</td>
<td>Real Estate</td>
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<td>79.0%</td>
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<td>Dividends</td>
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<td>Emerging Markets</td>
<td>32.6%</td>
<td>Dividends</td>
<td>16.2%</td>
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<td>Foreign Developed</td>
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<td>Small Caps</td>
<td>18.4%</td>
<td>Market Neutral</td>
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<td>Asset Allocation</td>
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<td>Small Caps</td>
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<td>Asset Allocation</td>
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<td>Asset Allocation</td>
<td>8.3%</td>
<td>S&amp;P 500</td>
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<td>Asset Allocation</td>
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<td>S&amp;P 500</td>
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<td>S&amp;P 500</td>
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| Cash                | 1.2%| Bonds | 2.4%| Dividends | 2.1%| Real Estate | -15.7%| Emerging Markets | -53.2%| Cash | 0.1%| Market Neutral | -0.8%| Emerging Markets | -18.2%| Dividends | -11.1%| Dividends | -9.5%| Dividends | 9.0%

Sources: Russell, MSCI, Dow Jones, Standard & Poor's, Credit Suisse, Barclays Capital, NAREIT, FactSet, J.P. Morgan Asset Management.

The “Asset Allocation” portfolio assumes the following weights: 25% S&P 500, 10% Russell 2000, 15% MSCI EAFE, 5% MSCI EMU, 25% Barclays Capital Aggregate, 5% Barclays 1-3mo. Treasury, 5% CS/Tremont Equity Market Neutral Index, 5% DJ UBS Commodity Index 5% NAREIT Equity REIT index. Rebalanced annually. All data represents the total return for the stated period. Indexes are not investable and do not include the impact of expense ratios or taxes. Past performance is not indicative of future returns.
Be in the Know About Legal Aspects of ACOs

Physicians need to become familiar with a variety of issues relative to accountable care organizations (ACOs) under the Medicare Shared Savings Program so they can make informed decisions about whether to participate, or wait and see if these organizations take root. MSMS has created a new Legal Alert exclusively for members called “What Physicians Need to Know about Accountable Care Organizations under the Medicare Shared Savings Program.” Download at www.msms.org/hcd.

2004-2013? Emerging Markets, with a 197 percent cumulative return. Looking back, the temptation would be to add to this hot sector in 2007 after it had been a top performer in the previous four years, but Emerging Markets dropped the fastest during the financial crisis of 2007-2008, leaving novice investors with significant losses and an aversion to stocks. The Asset Allocation portfolio, on the other hand, represents a diversified mix of asset classes and generated a 10-year return comparable to the S&P 500 but with less volatility.

“Fund investors have been buying and selling at the wrong times… but it’s no surprise,” reports Russell Kinnel, Director of Mutual Fund Research for Morningstar. It’s well documented that investors tend to buy hot performers too late, only to flee when they cool off. Morningstar reports that this behavior, called "performance chasing," cost investors in domestic stock funds 200 basis points of return in 2010. In other words, investors would have made an additional 2.00 percent if they had stayed invested all year instead of buying and selling when they did.

Yet, investors in balanced funds, which hold a blend of stocks and bonds and are considerably less volatile, lost only 14 basis points (0.14 percent) of return to performance chasing. Why the big difference? Morningstar has found that more volatile funds consistently inspire more performance chasing. So beware: volatility will pressure you to abandon your investment strategy at precisely the wrong time.

How Do You Avoid Making This Mistake?
Diversify. This concept is often ignored by impatient investors, but will have a profound impact on helping you achieve your investing goals. A diversified portfolio contains exposure to multiple markets and strategies and behaves in a less volatile manner than over-concentrating in only a few asset classes. It may seem boring at times, but it can keep your investment account from dropping drastically in value, seemingly overnight, when a crisis hits. When combined with a periodic rebalancing strategy (taking profits from assets classes with gains and redeploying the proceeds to underperforming categories), you can realize steadier returns, lower volatility and greater peace of mind.

The author is President of WealthCare Advisors, LLC – an MSMS joint venture.

For More Information

Want to avoid common investing mistakes? Request a copy of our white-paper Eight Mistakes Physicians Make with Their Money and How to Avoid Them by contacting co-author Jim Niedzinski at 888-958-1990 or download a copy from our website at www.wealthcareadvisors.com.
Travelers’ Health:
What You Need to Know About Immunizations
An Update from the Michigan Department of Community Health

The Centers for Disease Control & Prevention (CDC) travel website includes this statement: “Before you travel, make sure you speak with your doctor.” Considering that (according to the Office of Tourism and Travel Industries) almost 60.1 million US citizens traveled internationally in 2012, this likely will affect your practice. Are you prepared to give guidance on travel?

It is essential that your patients take steps to ensure a healthy trip. The CDC recommends a pre-travel consultation visit at least six weeks before departure from the United States. It should be conducted in a clinic prepared to offer travelers advice and recommendations specific for their destination and itinerary. It should include patient counseling on topics such as safe food/water, insect/animal avoidance, body fluids, hygiene and medical care abroad. It also should cover topics ranging from what to pack, traveler health notices [including safety warnings on non-vaccine preventable diseases to vaccine preventable diseases (VPD)], and advice for any follow-up actions needed upon return to US. The best resource for this information is free and can be found within the CDC travel website at www.cdc.gov/travel. Physicians and other health care providers can enter the traveler’s destination and click on the topics listed to prepare to counsel patients on travel precautions, considerations and recommendations.

It is essential that immunization status be evaluated early enough to allow time to complete vaccine dose recommendations. For instance, using minimum intervals, a hepatitis B series takes at least 16 weeks to complete. Physicians and other health care providers also should be aware of the resurgence of certain diseases – such as rubella and measles – and the increased risk of diseases like hepatitis A, hepatitis B, rotavirus, and meningococcal in certain countries or areas. For example, the measles resurgence in Western European countries (United Kingdom, Romania, Turkey and Indonesia, to name a few) have attributed to higher case counts internationally. In the US, 175 measles cases were reported by December 2013, (higher than a typical year at 60 cases) with Michigan accounting for five cases. The vast majority of US measles cases are linked to US residents traveling internationally without adequate immunization protection.

When It Comes to Travel and Immunizations, Ensure These Steps are Followed:

- **STEP 1:** Inform the traveler of the importance of receiving all routinely recommended (e.g., influenza, MMR) and travel vaccines well in advance of departure to ensure protection.
- **STEP 2:** Check the age-appropriate CDC Recommended Immunization Schedules at www.cdc.gov/vaccines to determine which vaccines are needed based on routine or high risk recommendation.
- **STEP 3:** Check the CDC Travel website – www.cdc.gov/travel – to determine other vaccines that may be indicated such as Yellow Fever or Japanese Encephalitis.
- **STEP 4:** Check the person’s immunization record, including the Michigan Care Improvement Registry (MCIR) to assess current vaccine status. Fact: 8.2 million children and adults have a record in MCIR; these records contain over 100 million separate vaccine entries.
- **STEP 5:** Vaccinate! Travel clinics should be prepared to offer all routinely recommended, high risk and travel vaccines. Other providers should ensure vaccination following the routine schedule and refer to a travel clinic or local health department that stocks travel vaccines for further vaccination.
- **STEP 6:** Record all vaccines doses administered in MCIR – for children and adults. If you do not have access, visit www.mcir.org for guidance. Give every person an updated vaccine record prior to leaving your clinic and recommend they carry it with them, especially when traveling outside the US.

Ensuring adequate protection against VPDs is essential to the health of your patients – both those traveling internationally and those who are “waiting” at home. Advise and vaccinate travelers to ensure a safer, healthier trip.
Michigan 7,325 – Mississippi 23
By Cindy Ackerman

These numbers reflect the kindergarteners exempted from vaccinations last year. Public Health Codes in both Michigan and Mississippi require that children are vaccinated before they can attend school. However, in Michigan, many parents choose to sign Immunization Waiver Forms. According to the Centers for Disease Control & Prevention, Michigan has the fourth-highest vaccination exemption rate in the nation. In Mississippi, childhood vaccinations can be waived only for medical reasons. In Michigan, they can be waived for religious and philosophical reasons too. Last year, 5.9 percent of Michigan’s kindergarteners entered school unvaccinated. Of these, 0.6 percent “opted out” for medical reasons and 5.3 percent for religious or philosophical reasons. As the number of Michigan children on waivers increased, so did the cases of measles and pertussis.

Like sanitation and clean water, vaccinations are one of the most effective public health measures ever introduced. They save millions of lives every year. A mandatory immunization program such as Mississippi’s would certainly lower Michigan’s exemption rate. However, Michigan’s voluntary vaccination program could gain momentum with “strong institutional leadership and robust educational campaigns.”

Pat Krehn, RN, BSN, a nursing supervisor with Public Health-Muskegon County, reports that the majority of waivers in Michigan are signed by highly educated mothers. These moms learn about vaccinations on the Internet rather than from their physicians. In some Michigan counties, when parents sign a waiver, the health department steps in to provide parents with factual information. Armed with the facts, parents frequently reconsider the waiver and vaccinate their child.

Parental education and awareness is a critical part of the immunization equation. This is where the MSMS Alliance can make a difference. We believe that Alliance members are uniquely positioned to educate parents about this public health issue. Like the moms who sign waivers, most Alliance members are also highly educated parents. MSMSA is promoting immunization as part of our health promotion program this year and next. County Alliances are encouraged to conduct a “project in a day” that focuses on vaccination education. Some options: organize and host a public forum or speaker; sponsor a billboard; distribute flyers; speak out on social media. It is our hope that these efforts will lead to fewer immunization waivers and more disease protection for all Michigan residents.

The author is President of the MSMS Alliance, comprised of physicians’ spouses.
The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Community Health Bureau of Health Professions.

**Report Dated 9-09-2013 – 9-13-2013**

Waddah H. Ghebe, MD
Taylor, MI
3-01-073451
09/20/2013
Technical Violation of the MPHC
Summary Suspension
Carlos Max, MD
Miami, FL
43-01-029712
08/28/2013
Reprimanded, Probation
Fine Imposed
Failure to Meet Cont. Ed. Requirements
Kenneth S. Merriman, II, MD
Hastings, MI
43-01-035154
09/20/2013
Summary Suspension
Violation of General Duty/Impairment
Criminal Conviction - Drug Related

**Report Dated 9-16-2013 – 9-20-2013**

Victor Abirag, MD
Grosse Pointe Shores, MI
43-01-037600
10/11/2013
Probation, Fine Imposed, Reprimanded Failure to Meet Cont. Ed. Requirements
Emanuel Joseph, Jr., MD
East Elmhurst, NY
43-01-067084
10/18/2013
Fine Imposed
Failure to Report/Comply
Sister State Disciplinary Action


R. Charles Medlar, MD
Jackson, MI
43-01-036871
09/18/2013
Voluntarily Surrendered
Failure to Meet Cont. Ed. Requirements
Robert Charles Legg, MD
Troy, MI
43-01-053320
09/18/2013
Probation
Violation of General Duty/Negligence
Failure to Report/Comply


Charles Ray Alderidge, DO
Saint Joseph, MI
51-01-008526
10/03/2013
Reprimanded, Fine Imposed, Probation
Failure to Meet Cont. Ed. Requirements


Paul Henry Musson, MD
Flint, MI
43-01-045140
10/24/2013
Reprimanded, Fine Imposed, Probation
Failure to Meet Cont. Ed. Requirements

**Report Dated 11-04-2013 – 11-08-2013**

Mark Paul Kallaway, MD
Alpena, MI
3-01-070855
11/15/2013
Summary Suspension
Substance Abuse
Mental/Physical Inability to Practice
Violation of General Duty/Negligence

**Notice of Intent to Deny** – formal document that indicates the Department intends to deny the issuance of a license because of violations of the Public Health Code, past or current.

**Probation** – a disciplinary action in which the licensee's practice is conditioned for a given period of time or until specific requirements are met. Probation can include conditions such as:
- participation in the Health Professional Recovery Program
- submission of regular reports from employer or other specified individual
- completion of specific continuing education requirement
- no violations of the Public Health Code
- other conditions deemed appropriate.

**Reinstatement** – the granting of a license with or without restrictions or conditions to an individual whose license was suspended or revoked.

**Reprimand** – the written statement of reprimand from the Board that specific activity of the licensee was a violation of the accepted standards of practice.

**Revocation** – a license can not practice for a minimum period of three years; if the violation involved controlled substances, the licensee can not practice for a minimum of five years.

**Suspension** – a licensee can not practice for a specified period of time.

**Summary Suspension** – if the actions a licensee are considered a threat to the public’s health and safety, the right to practice can be withdrawn immediately. The Summary Suspension orders the licensee to stop practicing immediately upon receipt of the summary. The summary is hand-delivered to the licensee.

**Summary Suspension Dissolved** – the summary suspension has been removed after an administrative review and the licensee is either allowed to practice or is subject to other disciplinary actions imposed by the Board.
Welcome to These New MSMS Members

Hasan A. Al-Janabi, DO, Dearborn
Josephine F. Aloot, MD, Rochester
Tara C. Bartlett, DO, Grand Blanc
Phyllis P. Birkel, MD, Rochester
Corinne M. Brown-Robinson, MD, Coldwater
Robert M. Cook, MD, Saginaw
Natalie A. Debernardi, MD, Swartz Creek
Michael J. Debo, DO, Grand Blanc
Larissa Dunker de Jesus, MD, Comstock Park
Andrew Keith Gunderson, MD, Grand Rapids
Christina Lynn Harsant, MD, Ypsilanti
Cynthia Renee Horning, MD, Flint
Anjan Kumar, MD, Northville
Warren F. Lanphear, MD, Grand Rapids

Alexander D. Lund, MD, Madison Heights
Jonathan R. Lynch, MD, Detroit
Nada C. Macaron, MD, Clinton Township
Carmen M. McIntyre, MD, Detroit
Madhavi Latha Nagalla, MD, Ann Arbor
Dipa S. Patel, MD, Grand Rapids
Shilin Patel, MD, Wayne
Vincent E. Pesiri, MD, Jackson
Ayesha Phillip, MD, Flint
Rachel H. Plum, MD, Traverse City
Sarah Sanchez, MD, Flint
Harpreet Singh, MD, Big Rapids
Robert J. Veenema, DO, Grand Rapids
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“Pardon me, Doctor; but exactly where did you study anesthesiology?”

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The Growing Void of Leadership Training in Medical Education

by Kenneth Elmassian, DO

The theme of this issue of Michigan Medicine is Graduate Medical Education, with all the headaches and ramifications of that topic. Certainly, GME issues are a growing concern for health care, and indeed for American society overall; and funding, accreditation, and curricula are among the hot topics discussed in this issue.

However, I’d like to step back and offer a broader take on medical education, and indeed, the quiet crisis in medical education overall. There is an urgent, growing need to update the curricula for our medical training in America today—from undergraduate all the way through residency programs—to better prepare tomorrow’s physicians for the future.

At a moment in history when health care funding, structures and technology are shifting radically, the education of our physicians remains behind the curve. Skills that are now vital for the physician—such as communication, working in and leading teams, and seeking efficiencies in care—remain scarce in our medical curricula.

Yet these are just the skills needed if tomorrow’s physicians hope to be the leaders in setting health care standards. Tightening resources and radical changes in health care structures demand that physicians learn these new skills—or become stampeded by them. Thomas H. Lee, MD, writing in the Harvard Business Review, noted, “Health care delivery is fragmented and chaotic… Taming this chaos requires a new breed of leaders at every level.”

Yet how can physicians tame, or even survive, this chaos without ongoing training keyed to modern realities? At a recent AMA Section on Medical Schools program on waste of medical resources, Steven E. Weinberger, MD, FACP, executive vice president and chief executive officer of the American College of Physicians, cited a survey finding nearly two in three residents had no idea about the cost of medical tests. Doctor Weinberger saw this figure as “ridiculous”—as in ridiculously optimistic. “It’s probably really 98 percent or 99 percent.”

In talks with medical students, I find them hungry for this real-world training on modern medical practice, but also facing a void in it. They tell me they do not receive training on teamwork, on managing and leading in new practice arrangements, or on stewardship and cost-cutting of care dollars.

Consider just one example: the new “medical home” model of health care reform. This will demand leaders who are able to manage diverse care teams, and keep an eye on profitability and wise use of resources. For physicians to take the lead, we’ll need to be able to lead large groups of talented people in making care decisions in real time. Too much of our traditional training taught us to be solo practitioners, when the coming job description for a physician reads more like a football quarterback.

This training void hurts the management of resources, but it will bring even greater, long-term harm to medical care itself. If we as physicians do not know how to be leaders in our practices, how can we lead in health care overall? How can we serve as advocates of our patients, in setting health care policy, in the legislative process, if we lack the tools to engage in that process? If tomorrow’s physicians do not participate in this conversation on priorities and allocation of health resources, that creates a vacuum. This vacuum will surely be filled—but maybe not by voices who will advocate for the primacy of patients and high standards of care.

There are bright spots in future medical education. The new AMA grants for innovation in medical training will fund valuable pilot programs, such as the one at the University of Michigan Medical School. Yet the AMA’s $11 million in funding is only a start in the overhaul medical education in America demands. Our medical schools in Michigan have a golden opportunity to lead this revolution in medical education, but we must begin now. Otherwise, today’s void in medical training will become tomorrow’s chasm.

Doctor Elmassian, a Lansing anesthesiologist, is President of the Michigan State Medical Society.
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